Major Developments in the States: 1997

Whether the issue was "partial-birth" abortion, contraceptive insurance coverage, Medicaid expansions for family planning or prevention of teenage and out-of-wedlock births, last year's most significant reproductive health-related developments revealed intense interplay between federal and state policies and programs.

By Rebekah Saul

In 1997, the potency of policymaking cross-pollination between the federal government and the states was amply demonstrated by efforts to ban so-called partial-birth abortion as well as moves to expand private insurance coverage of contraception. At the same time, the flood of activity spawned by the Medicaid program and the 1996 welfare reform law evidenced not only the influence of federal funding on state policymaking but also the diversity of initiatives that can be born through federal-state partnerships.

Banning 'Partial-Birth' Abortion

A firestorm of activity surrounding so-called partial-birth abortions continued in Congress and in state legislatures last year, as feuding over attempts to outlaw the procedure (or, more properly, procedures, since the term itself is vague) continued to dominate the abortion debate across the nation. While much of the focus was at the federal level—with Congress passing, and President Bill Clinton vetoing, a ban—by the year's end, the significant policy actions on this issue had shifted back to where they began: the states.

In 1995, Ohio made the first move in the antichoice campaign that immediately grabbed the attention of other state legislatures and federal lawmakers. In 1996, the first federal Partial-Birth Abortion Ban Act was passed by Congress and vetoed by the president. That year, Michigan enacted a bill that closely mirrored the federal legislation, and Utah moved to ban postviability "partial-birth" abortions.

Sparked by the failure of a second federal bill, the veto of which was overridden in the House but narrowly upheld in the Senate, the issue swept the country in 1997, receiving serious legislative consideration in half the states, and accounting for over one-third of all state abortion-related legislative activity in 1997. By the year's end, 16 new states had enacted laws (see table, page 9), bringing the number of enacted state bans to 19.

The last addition to the 1997 enactments came from New Jersey, where in December the legislature overrode Gov. Christine Todd Whitman's (R) earlier veto of the ban. At that time, the governor stated that the ban had constitutional limitations and recommended instead that the legislature propose to prohibit postviability abortions except when necessary to protect the life and health of the woman, a strategy which also was tried and failed at the federal level last year. The legislature rejected her recommendations and, instead, with barely enough votes, overrode Whitman's veto.

Most Bans Blocked or Limited

In both the federal and state arenas, lawmakers pursued "partial-birth" abortion bans despite practical barriers: at the federal level, presidential vetoes and, in the states, court declarations of unconstitutionality. In every state where a ban has been challenged, enforcement of the law has been blocked or limited by federal or state court or attorney general opinion, including permanent injunctions in Ohio, Michigan and Arizona. (A U.S. court of appeals upheld the lower court's injunction against the Ohio law; that case appears to be on its way to the U.S. Supreme Court.) As a result of these legal actions, by the year's close, only six state "partial-birth" abortion laws were in full effect.

There has been some consensus in the courts over the constitutional problems inherent in the "partial-birth" abortion bans. Primarily, courts have agreed that the definition of the procedure is so vague that it might also outlaw second-trimester abortions by a range of methods, thereby unconstitutionally posing an "undue burden" on a woman's ability to obtain an abortion prior to viability. The failure of these laws to meet constitutional muster in the courts, however, has done little to deter policymaking around this issue.

Expanding Access to Family Planning

Partly in response to wrangling over abortion and, in particular, later abortion, many legislators turned their attention in 1997 to the other end of the reproductive health spectrum: prevention of unintended pregnancy. As a result, in both the public and private sectors in 1997, initiatives aiming to expand access to contraception gained momentum.

MEDICAID WAIVERS EXTENDING FAMILY PLANNING COVERAGE

To Women After Postpartum Period	*To Women Losing Medicaid for Any Reason*	*To All Women in State Based Solely on Income*
Illinois Maryland New York* Rhode Island South Carolina	Delaware	Arkansas Michigan* New Mexico* South Carolina*

**Approved by HCFA in 1997.*

Private Insurance Coverage

Private insurance coverage of contraceptives emerged as a major reproductive health care policy issue for the first time last year on Capitol Hill and also gained unprecedented attention in state legislatures. The state and federal measures all are designed to redress the reality that many health insurance plans treat contraceptive methods and services differently, and much less generously, than general medical care. For example, according to a 1993 study by The Alan Guttmacher Institute, only 33% of traditional fee-for-service plans cover oral contraceptives, although 97% include prescription drug benefits. It comes as no surprise, then, that women of reproductive age spend 68% more in out-of-pocket costs for health care than do men, as found in a 1994 report by the Women's Research and Education Institute.

In 1997, for the second time in three years, California came breathtakingly close to enacting legislation that would mandate private insurance coverage of contraception. In 1995, Gov. Pete Wilson (R) bowed to vocal opposition by the insurance industry and small businesses and vetoed a contraceptive coverage bill. Last year, however, advocates appeared to have successfully addressed many of Wilson's concerns over the merits of the legislation. This time, Wilson's declared moratorium on signing new "managed care" legislation pending the conclusions of the state's managed care task force interfered with the measure's enactment; the bill's sponsor inactivated the measure instead of risking another veto. With that report finally released as the new year dawned, the decks are again clear for the legislation to move.

The contraceptive coverage issue spread last year from California to seven other states as well as to Capitol Hill. Virginia became the second state to enact a law requiring insurance plans to *offer* contraceptive coverage to employers purchasing plans. (Hawaii quietly enacted a similar measure in 1993.) While Virginia's law aims to ensure that all employers at least have the opportunity to provide employees contraceptive coverage, the measure does not ensure that such coverage will be included in a typical benefits plan and so, its practical effects may be limited.

At the federal level, the Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC) was introduced in both the House and the Senate. EPICC is based on the concept of parity; its rationale is to require policies that cover general medical care and prescription drugs to cover contraceptive services and prescriptions. While it saw no official legislative action beyond introduction by the year's close, EPICC had gained over 70 cosponsors in the House and more than 30 in the Senate. Along with state measures in California, Illinois, Massachusetts and New York, the federal bill carried over into 1998.

Medicaid Expansions

In the public arena, the federal Health Care Financing Administration (HCFA) last year approved four new Medicaid waivers intending to expand access to Medicaid family planning services. These recent approvals bring to nine the number of states capitalizing on the preferential treatment of family planning services under the joint federal-state Medicaid program by getting permission from HCFA (under the so-called section 1115 authority) to waive certain federal Medicaid eligibility requirements in order to expand Medicaid family planning coverage. States are reimbursed for 50–70% of the costs of other medical services, but the federal government will pay 90% of the cost of providing family planning services.

Prior to 1997, the most popular use of waivers had been to build on the Medicaid expansions for pregnant and postpartum women that were enacted by Congress in the 1980s; states largely sought 1115 waivers in order to extend the length of time—in some cases as long as five years—a "postpartum" woman could take advantage of Medicaid-funded family planning services. Last year, New York became the fifth state to receive approval of a postpartum waiver (see box). (Delaware remains the only state to have gained approval for a similar type of family planning expansion: the state allows women to maintain Medicaid family planning coverage for up to two years after losing Medicaid eligibility for any reason, not just postpartum.)

The other three newly approved waivers take Medicaid expansions one step further and, following Arkansas' 1996 move to do the same, will make Medicaid family planning coverage available to all women in the state based solely on income, regardless of whether the women have been on Medicaid in the past. California enacted a similar initiative in 1996, only that program

uses state dollars exclusively to extend Medi-Cal family planning services to all Californians at risk of unintended pregnancy with incomes up to 200% of the federal poverty level. (Because California decided to fund the expansion solely with state dollars, federal approval was not required.) Preliminary data from Arkansas and California suggests that these expansion programs can serve thousands of women previously ineligible for Medicaid family planning services.

All of these moves can be seen as both critical state efforts to maximize federal funding for contraceptive and related services for low-income women at a time when other federal family planning sources are dwindling (see related story, page 3) and as attempts by states to take advantage of family planning's proven cost-effectiveness.

Addressing Teen Pregnancy

In yet another federal-state interplay, teen pregnancy received a resurgence of attention in state legislatures last year, largely in response to two particular provisions—the federal abstinence program and the so-called illegitimacy bonus—of the 1996 federal welfare reform law. Through the abstinence program, Congress has made available $250 million over five years for states to implement programs that have as their "exclusive purpose, teaching the social, psychological and health gains to be realized by abstaining from sexual activity." The law requires that states meet the law's narrow, prescriptive definition of abstinence-only education in order to qualify for the federal funding. Unlike the abstinence funding, to which all states are entitled so long as they meet the program's requirements, the "illegitimacy bonus," sets up a competition: The federal government will award $20 million bonuses to each of the five states achieving the greatest reduction in their numbers of out-of-wedlock births, without increasing abortion rates.

Though both of these provisions were enacted by Congress with the goal of deterring all *out-of-wedlock* sexual activity and childbearing, they largely have served as the impetus for state consideration of *adolescent*-focused initiatives; as a result, over half of all serious teen pregnancy-related legislative consideration in the states last year can be seen as a response to welfare reform.

While many states addressed teen pregnancy by setting up committees or studies, a number of states specifically directed their department of health to apply for the abstinence funds and/or implemented a program that meets the federal abstinence requirements. Even more states, however, moved to implement broader educational strategies, which included but were not limited to abstinence education. And, four states—Arkansas, Maine, Mississippi and Rhode Island—enacted comprehensive teen initiatives that include a link to pregnancy prevention health care services (see table). Taken together, these initiatives demonstrate that, despite the narrow intentions of the federal law, states are taking a multifaceted approach to teen pregnancy prevention.

Outlook

In 1998, a year marked by state- and federal-level elections and the 25th anniversary of *Roe v. Wade*, it is virtually assured that antichoice lawmakers will work to keep "partial-birth" abortion in the legislative limelight. For their part, reproductive health advocates can be expected to look to utilize the anniversary of the legalization of abortion as an opportunity to demonstrate their interest in a broad reproductive rights agenda—focusing on prevention of unintended pregnancy while also affirming the importance of access to abortion. As a result, contraceptive coverage promises to keep its foothold in the state legislative agendas in 1998—by way of carryover legislation, new introductions and the imminent action in California—and EPICC promises to at the very least maintain its place in the center of the federal reproductive rights agenda. Also in this context, it can be expected that policymakers will continue looking for cost-effective ways to expand family planning services for low-income women.

Meanwhile, all eyes will be on the states in 1998 to see how the teen pregnancy initiatives inspired by welfare reform will play out. In light of the federal government's $250 million investment, rigorous evaluation of abstinence-only programs will be essential to determining their cost-effectiveness and also to making progress on one of the most difficult reproductive health issues of our time. In the teen pregnancy and other areas, the interdependence of federal and state actions will likely continue to increase, raising the policymaking stakes while also providing much-needed opportunities for research and evaluation efforts.

The research on which this article is based was supported in part by the U.S. Department of Health and Human services (DHHS) under grant no. FPR000057. The conclusions and opinions expressed in this article do not necessarily represent the views of DHHS.

State legislative consideration of selected reproductive health issues: 1997

State	Abortion	Family Planning	Teen Pregnancy Prevention			
	Ban so-called partial-birth abortion	Mandate private insurance coverage of contraception	Establish committee or mandate study	Institute abstinence-only education effort	Institute broader education-based effort	Institute comprehensive prevention initiative
Alabama	★					
Alaska	★					
Arizona	★		●	●		
Arkansas	★				★	★
California	●	●	▼	●	▼	●
Colorado	●					
Connecticut		●	●		★	
Delaware	●					
Florida	▼		★		★	
Georgia	★		★	★		
Hawaii		●	●		●	
Idaho						
Illinois	★	●				
Indiana	★					
Iowa				★	★	
Kansas	●					
Kentucky						
Louisiana	★		★		★	
Maine	●		●		★	★
Maryland	●					
Massachusetts	●	●[1]	●		●	●
Michigan						
Minnesota			★		★	
Mississippi	★		★	★	★	★
Missouri	▼				●	
Montana	★					
Nebraska	★					
Nevada				●		
New Hampshire	●					
New Jersey	★		★			
New Mexico	●					
New York	●	●			★	
North Carolina	●			★		
North Dakota					●	
Ohio				●		
Oklahoma	●					
Oregon		●				
Pennsylvania						
Rhode Island	★				★	★
South Carolina	★		▼		★	
South Dakota	★				★	
Tennessee	★					
Texas						
Utah					★	
Vermont						
Virginia	●	★[1]				
Washington	●		●	★	●	
West Virginia	●					
Wisconsin	●					
Wyoming						

1 Mandates only that plans offer contraceptive coverage

Key: ★ = legislation was enacted; ● = legislation was seriously considered; ▼ = legislation was vetoed.